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TIC
A MAGAZINE FOR
DENTISTS
DENTAL HYGIENISTS
DENTAL ASSISTANTS

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May 1961 Vol. XX No. 5

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MALPRACTICE AND FRIENDLY RELATIONS

By KAY LIPKE WARREN

Every reputable dentist desires to succeed in his profession. He wishes to succeed financially, of course. But, more than this, to give the best of his ability and experience to his patients, and thereby establish a practice based on the confidence of his patients in his skill and reliability.

Above all, he wants to keep out of trouble.

With the steadily mounting number of dental malpractice cases reaching the courts throughout the country, this ability to keep out of trouble becomes one of the most valuable assets a dentist can have.

Certain dentists find themselves sued many times by disgruntled patients, while others, with perhaps no greater skill, go through their entire dental careers without even one malpractice suit.

What is the reason?

According to Harry Keeling, well-known insurance expert and counselor in Southern California, a dentist who can say he has never been sued—or threatened with a malpractice suit—after actively practicing ten or more years, is a man who has developed the fine art of liking people and getting along harmoniously with them.

It is Mr. Keeling's firm conviction that good relations between a dentist and his patients, and his ability to win and hold their confidence, serves as a protective insurance against the possibility of a malpractice suit.

To illustrate his point, he tells the case of a dentist who recently thought he was going to be involved in a malpractice suit. A dental handpiece slipped and nicked a patient's tongue. The dentist felt upset about the accident, of course, and thought the patient would take legal action. However, the patient was friendly and understanding, and never thought of making trouble.

The warm confidence which existed between that dentist and his patient warded off a possible suit. In other words, the dentist had made a friend of his patient and, when trouble arose, the dentist was treated as a friend in return.

By direct contrast, there is another kind of dentist who has been sued again and again, because he has always adopted a seemingly high-handed manner toward his patients, treating them with

chill professional reserve, and never bothering to take time to establish friendly relations with them. No matter how expensive and beautiful his office suite, or how technically skilled his work, his patients resent his manner—and feel no compunction about suing him when the situation arises.

Money problems often cause trouble which can take a dentist to court, especially fees, when the patient has no idea of the amount being charged. If he expects to pay $200 or $300 for dental work and receives a bill for $1,000, naturally there is trouble.

Every dentist should talk over the amount of the dental fee with the patient and explain the reasons for the charge. If there is any disagreement over the amount, it should be discussed before the work is done and an agreement reached.

Above all, Mr. Keeling advises dentists to take time to listen to their patients and understand their problems. A few moments spent beside the dental chair showing friendly interest may save hours of worry and possible great financial loss later in a courtroom.

Mr. Keeling knows whereof he speaks. Not only does his company issue malpractice insurance to a great majority of the Southern California dentists, but he teaches dental jurisprudence in the University of Southern California School of Dentistry and the College of Medical Evangelists School of Dentistry. He is also insurance counselor to the Southern California State Dental Society, and edits a pamphlet called *The Counsellor* for its members, alerting them to current problems in the malpractice field.

The malpractice problems in Southern California are many, for this community has the unenviable distinction of having an unusually high rate of malpractice cases, due principally to the enormous increase of population, the leniency of the courts toward those starting suit, and the large number of lawyers who specialize in this type of case and who will go to dramatic lengths to win each case.

Furthermore, California law is complicated by the doctrine of *res ipse loquitor* (the thing speaks for itself) which, if evoked, creates either a presumption of negligence or an inference of negligence. Usually in court the defendant is presumed innocent until proven guilty, but under this doctrine the dentist is presumed guilty until proven innocent. All that the patient has to do is to testify that an accident occurred and give proof of it and the dentist is in trouble.

Because of the malpractice situation in Southern California, a great effort has been made to alert the dentists to the problem and to educate them in ways of avoiding trouble. There are two ways. One is by "malpractice prophylaxis"—the preventing of trouble before it occurs. The other is to do something when trouble does take place.

Check Medical History

As a preventive measure, every dentist should have patients check and sign medical record cards giving their medical history. When an extraction is indicated, there should be a signed card from the patient giving consent to the extraction.

For instance, there was the case of a patient who had a tooth extracted under sodium pentathal. During surgery the patient died. Some weeks later an attorney appeared on behalf of the patient's widow, threatening suit. He said the patient had a severe heart condition, and the dentist should not have administered a general anesthetic.

The dentist produced the patient's medical record card, signed by the patient, on which the patient had stated that he had had no heart condition and had not consulted a physician during the past two years. Furthermore, he had asserted he was in good health.

"But that is a lie," the attorney protested.

"Perhaps it is," replied the dentist. "However, it is the patient's lie, not mine. I operated in the honest belief that the patient was in good health." The case was dropped. Without that signed card, the dentist would have been in serious trouble.

Problem of X-rays

Another preventive measure strongly advocated by Mr. Keeling is that each dentist take his own x-rays. Very often, when x-rays are sent to an oral surgeon by the referring dentist, there is the possibility that they may be mounted wrong. Some dentists mount their x-rays one way and some another, and there is always the danger of the wrong tooth being extracted, with a possible malpractice suit as a result.

"I REHEARSED MY DENTAL SOCIETY SPEECH 50 TIMES AND IT STILL DOESN'T SOUND IMPROMPTU!"

DENTISTRY AFTER DARK

Yes, nurse, I can take it easy next week.
It's only a seven-nighter—kind of a freak.
The last patient's out at five or so,
Then over my books I'll gaily go.

That's Monday. Now Tuesday night all I do
Is read that paper on "I'm Human, Too."
I'm solid on Wednesday from seven to ten
With that brush-up course on occlusion again.

Thursday's my night with the halt and lame
(The hospital needs me in charity's name).
Now Friday evening will be like cheating.
I'm running the film at the dental meeting.

I'll get a chance Saturday, one really rare,
To fondle my lab work with loving care.
There's still Sunday night and that's the one, buddy
When I can sit up until midnight and study.

Ralph W. Andrews

Still another preventive measure is the care a dentist should take with handpieces. It is wise to move a little slowly, use a retractor to protect the patient from the handpiece, and be careful to hang it on a hook so that it does not drop and injure the patient.

Watch Your Handpiece

A handpiece is one of the most frequent causes of dental accidents and subsequent malpractice when it slips and hurts a patient. The only defense dentistry has against such a case is contributory negligence. Dentists are advised to keep cool when such an accident occurs so that they are able to judge if the patient contributed to cause the accident by a sudden jerking of the head, or by making some quick movement which sent the handpiece in the wrong direction. If the patient had a part in the accident, he should be made to realize the fact at once to prevent the possibility of a suit.

Value of Counseling Committee

In order to prevent grievances from going to court, the Los Angeles County Dental Society Counseling Committee has been formed. It serves as liaison between the injured party and the dentist involved. The committee receives in writing the complaint of the patient and submits this complaint to the dentist, who replies, giving his side of the story. If it is indicated, a panel is appointed to investigate and examine the work done by the dentist. This committee has done much to arbitrate cases and prevent them from reaching the courts.

Although the committee is composed of dentists, the decisions handed down do not always react favorably toward members of the profession. Recently a dentist was compelled to refund a large fee because it was felt that the work done was inadequate.

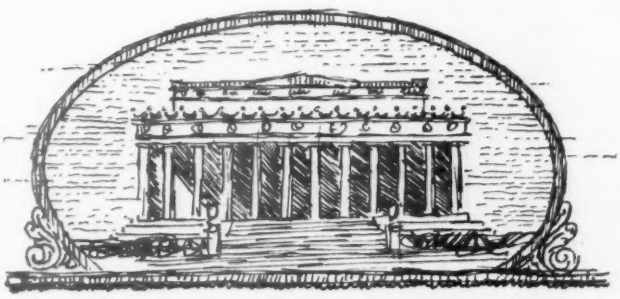
However, a great many dentists themselves will refund fees when, after exerting their best efforts, they find that a difficult patient refuses to be satisfied with the work done. The good will of the patient is more important than the amount of money involved.

The confidence and the friendship of patients mean a great deal to a reputable dentist who has practiced his profession for many years. He is as proud of this friendship as he is of the quality of the work he has done.

He has earned this confidence by taking time to show an interest in the patients who sit in his dental chair and often take up valuable time telling him their problems. Although he probably does not know it at the time, by establishing friendly relations with the people whose names are in his dental files, he has also helped to insure himself against possible malpractice.

When a dentist does unto others as he would have others do unto him, a good many of his dental problems would seem to disappear.

1993 Lucile Avenue
Los Angeles 39, California



PIONEER:

The Story of the Oldest Living Member of the American Dental Association—Dr. John E. Storey of Beaumont, Texas

By ALLEN YOUNG

An unpretentious white shingle hangs near the curb at 2402 North Street, Beaumont, Texas, marking the residence of the oldest living member of the American Dental Association.

It reads: Dr. Storey, Dentist.

But it tells too little, and deserves expansion, because John E. Storey, 93, would be a legend in his own right if he had never filled a tooth.

For a number of his early working years, Dr. Storey alternately practiced his profession and pitched camp on the virgin prairie of the young Southwest; filled and cleaned teeth and swapped lore and favors with the Indian tribes of Arizona, New Mexico and Texas; packed into the game-filled Oklahoma country on hunting trips, and met good and bad men of repute.

And he carried a .45 with the best of them.

"A man would put it on in the morning when he put on his pants."

John Storey was born in Emory, Virginia, and came to Dallas with his family when he was eight years old, arriving at the Texas and Pacific terminus when it was at Eagle Ford, six miles west of Dallas. He spent a happy, exuberant childhood and early youth in Dallas; then returned to Virginia and studied at Emory and Henry in his hometown; and

finally entered the Baltimore College of Dental Surgery.

He was 25 when he received his certificate as a practicing dentist, but he had already gotten five years of practical experience in his father's office in Dallas.

He returned to Dallas, armed with his professional credentials, and found the going sticky.

"In those days (1892) it was an old man's age. People didn't trust anyone unless he was 50 or so...."

So he drifted. He went into Arizona and New Mexico while they were still blustery territories with precious little notion of statehood.

"I was in that country before Douglas, Arizona, was even heard of. Now it's a big town."

He moved among the Indians, gathering ideas and history and, in the process, an array of artifacts that comprise a wonderful, and valuable, collection today.

While we talked, he mentioned names that read like a who's who of the early West.

Doc Holliday.

"He was a graduate of the same dental school I attended."

Wyatt Earp.

"In the first place, the name was pronounced Arp, though it's Urp on television today. And when he was Marshal of Tombstone he didn't carry two guns. He didn't even carry one. He kept sawed-off shotguns at every barroom in town! Doc Holliday also used a shotgun, and kept it under a fashionable Prince Albert coat."

Frank James.

"I knew Frank James well. I played poker with him quite often."

Sam Bass.

"Some of his men (from Denton) ate right here with me in the early days."

After about eight years of voluntary Odyssey, Dr. Storey came to Beaumont in June 1907. He had married in Midland and brought his wife to the little city of about 10,000 at Tevis Bluff on the Neches, 30 miles above Sabine Bay and the Gulf. He jumped right into an active dental practice, but still found time for his beloved outdoors.

"I taught the men in this country how to fly-fish. I put the first fly in Village Creek that year."

While we talked about fishing, he instructed me to bring his fly rod, kept handy behind a nearby door.

"I'll bet you that you don't know how to hold that thing," he challenged.

I had more than a passing acquaintance with several of the limber switches myself, and so I confidently grasped the cork handle, with thumb extended along the top ridge of the grip.

"I thought so!" he exploded. "Hand that thing to me."

He took the rod and gripped the handle loosely. Where my thumb had gone, he put his forefinger. He showed me how this grip enables him to cast almost effortlessly, using only the hinge of the wrist, not the muscles of the forearm, and allows the caster to literally point his finger at the spot where he wants to place the fly. (I tried his method on a bayou near Beaumont later. It works.)

At 93, John E. Storey is just beginning to live, because life is still a very vital thing for him. His philosophy would keep anyone young.

"I don't clutter up my disposition with hate. If I don't like people, I ignore them. I just don't have time for ill-will."

He figures that he has about $30,000 owing him from a career in dentistry.

"If people used me, I just wrote them off the books."

Before his wife died last year—they had been married for 60 years—the Storeys traveled all over America.

"For 40 years we took two months out of each year and drove all over this magnificent land. I love the country all around Beaumont, and I love Texas. But America is my country, and America I've seen, in all her beauty."

There is a lot of beauty in the man himself.

Beaumont, Texas

a plan for:

IDENTIFICATION BY DENTURES

By R. B. MOORE, D.D.S.

"Doctor, I am not sure it's my boy. I'll never be sure that the body is my son until you identify his teeth," the World War I Gold Star Mother told me after she had asked me to identify some fillings I had placed in her son's teeth before he entered the army.

Then came other wars and other mothers asked dentists to identify the bodies of their sons—from their teeth. Every serious plane crash or automobile accident where bodies can be identified by teeth gradually increases the importance of dental record cards for identification purposes. I recall how the body of film producer Mike Todd was identified by his teeth.

But what are we, as dentists, going to do to make dentures play the fullest role possible in the identification of bodies? This is not a great problem to solve. But it will be a great undertaking for dentistry. From time to time I have had cases where a former service man came to me for repairs or adjustments to dentures which were made in the Walter Reed Hospital and other military installations where names or initials have been embedded under a layer of clear acrylic for identification purposes. In such cases, the names, initials or codes have been printed on tiny tabs of special paper and placed on either side of an upper denture near the second molar. Such identifications are ideal for many purposes. But in case of fire when the charred body must be identified, such identifications are inadequate.

So let us all unite now and promote experimental clinics on the uses of stainless steel initials or nameplates, which can easily be embedded under a layer of acrylic and placed in dentures for identification purposes—for personal reasons or in case of fire.

During my days at the University of Iowa, my professor of anatomy asked me to conduct a tour of 6 members of the Iowa Legislature through the dissecting rooms. I recall vividly my own cadaver, the body of a young woman between the age of 18 and 24 years. Next to her was the cadaver of an elderly woman. From features and characteristics, neither body looked as if it should be food for a Potter's Field. I wondered if dentistry could have played an important part in the identification of that young woman with an amalgam filling in a molar, or whether that elderly woman had a living relative who did not know what had happened to her.

Since that time, the bodies of young persons are often identified by their teeth—if dentists keep record cards. But someplace along the line, we have failed to promote personalized identifications of stainless steel—the backbone of dentistry—for acrylic dentures or all kinds of oral appliances.

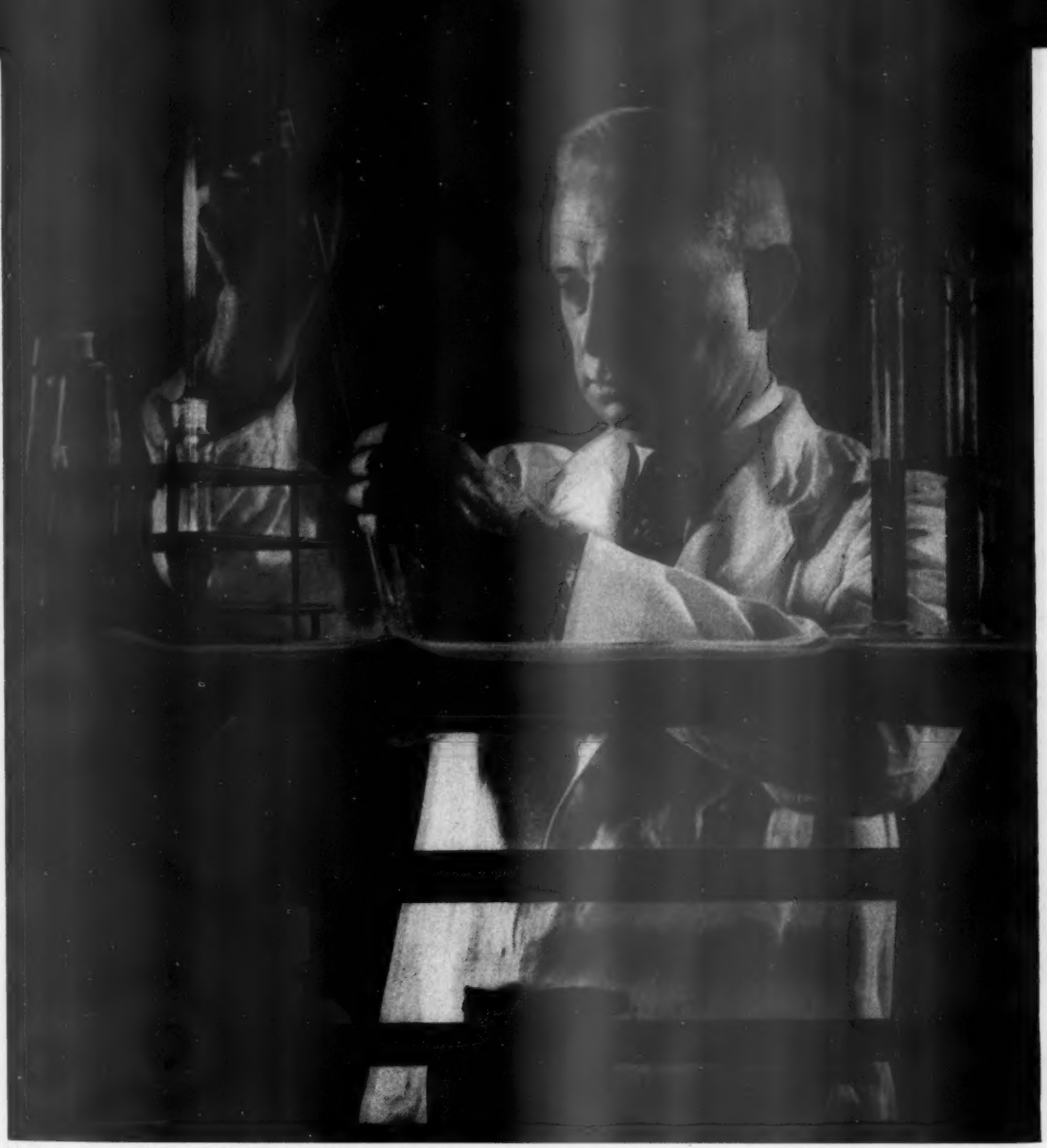
There are many ways by which stainless steel can be used for permanent identification purposes. Social Security numbers can be reproduced on tiny plates. A letter and a number can be used to identify the patient from a permanent record card. Franchised materials can be identified with a code which can be as small as a tooth manufacturer's trademark on the back of a central.

Every upper denture could have a personalized identification on one side for the patient and a code for dentists on the opposite side. The letters IR could mean "Immediate Restoration" and in such cases if the patient moved to another vicinity and went to another dentist—after absorption—the next dentist would know that "Denture No. 1" is before him. A code of IR2 could mean "Immediate Restoration" and "Patient is wearing second denture."

To keep one dentist informed as to the patient's health and mental problems, such codes could be devised as A for "Anemic," B for "Bleeder," and so forth. Yes, we as dentists could devise an entire code for our own identification purposes, just as other facts are placed on permanent record cards.

Right now is the time to experiment in our own laboratories and to conduct clinics for such purposes. To start such a program all we need is one dentist in each county to call on the county sheriff and find out how many bodies have been unidentified because the patient was wearing dentures and there was not a tooth left for identification purposes.

There is a great future in personalized dentistry for identification purposes.



Scientists at the NATIONAL INSTITUTE of DENTAL RESEARCH engage in basic studies of the chemical and physical nature of collagen, a major protein of both hard and soft tissues of the mouth.

Dental Research

All over the United States dental research scientists are working at projects designed to prevent the loss of teeth through decay, through disease of the gums, or through other causes. The sum total of the objectives of these many studies is to learn how it is possible for man to retain his natural teeth during his entire lifespan.

That great, overall goal seems impossible when one considers that loss of teeth through disease is the most widespread affliction of the human race, affecting almost everybody; that by age 40 the average adult will have lost half of his teeth; that six out of every seven adults have a gum disease, the main cause of tooth loss in adults; and that 95 percent of all 15-year-olds now have decayed permanent teeth.

Dental Research

THE ROAD T

(ALL PHOTOS—NATIONAL INSTITUTE OF DENTAL RESEARCH)

Here, a specially designed amino acid analyser is used by dental scientists to obtain precise data in the study of oral diseases.

BOOK TWO: CHAPTER V

Dental scientists in this country have made a start on the road to realization of lifetime preservation of natural dentition. Here are some indications of that progress:

Through the awarding of research grants by the National Institute of Dental Research of the U. S. Public Health Service, studies are being conducted in more than 90 non-governmental institutions throughout the nation and seven foreign countries. In addition, a broad program of laboratory and clinical research is under way at the Dental Institute's modern facilities in Bethesda, Md. Moreover, the nation's manpower pool of dental scientists and teachers is being expanded through graduate training grants awarded by N.I.D.R. to dental schools and other institutions. The American Dental Association is also supporting and encouraging clinical explorations with the aim of providing Americans with the highest standards of dental services in the world.

Fluoridation of water supplies, a development of the last quarter-century, is already making it possible for two out of three children to reduce tooth decay by 60-65 percent.

ARABIAN NIGHTS IN DENTISTRY

TRAL HEALTH

Through the use of germfree rats, scientists have been able to study the influence of certain mouth bacteria on tartar formation, dental decay, and pyorrhea. Special apparatus, designed to maintain germfree animals in sterile environment, is seen in background.

THEORETICALLY, scientific knowledge now at hand, if applied, ought to insure every child from ever losing a tooth through decay. The know-how of applying this information, which will make this tremendous achievement possible, is being developed.

A breakthrough in another riddle of dental disease is getting closer. Artificially induced fever in pregnant rats, experiments show, causes dental malformations in the mother and the offspring. A cancer-producing agent changes the microscopic appearance of embryonic "tooth germs" to resemble that of malignant tumors. Of possible significance to the health of all mankind is the knowledge that the general health of individuals is reflected in the tissues of the mouth. This has possibilities for early diagnosis of health disorders and oncoming illnesses via mouth examinations.

These findings are but a few representative products of the many Institute-sponsored research projects being carried on by all the nation's dental schools, many hospitals, local health departments, and other research facilities.

The dental profession believes that the oral health of just about everyone can be immeasurably improved, that dental decay and tooth loss can be reduced and eventually eliminated altogether, and that most children will be able to retain most of their teeth all their lives if:

1. Research into all aspects of dental disease is stepped up.
2. The resultant scientific knowledge and know-how are made available to dentists, dental students, and the public.
3. Present and future dentists employ this new information and these new technics in treating dental patients and in conducting wide-scaled prevention programs for children and adults.

WITHIN a relatively few years, dental research has already made it possible for hundreds of millions of children to realize a higher standard of oral health than any other generation in history has enjoyed. This is part payment of the promise of total oral health for all.

ARTIST'S SKETCH of the new research laboratories of the NATIONAL INSTITUTE OF DENTAL RESEARCH, one of the seven National Institutes of Health of the Public Health Service. This $3,700,000 structure contains the most modern scientific equipment and accommodates some 200 researchers.

LOSS OF TEETH

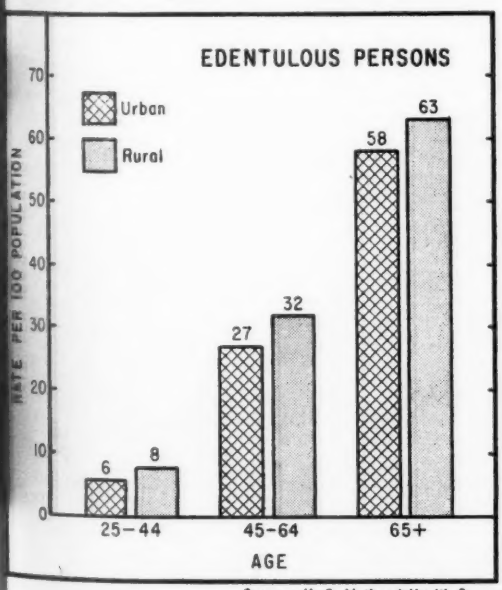
ADAPTED FROM A REPORT PREPARED
By JANE W. BERGSTEN
U. S. NATIONAL HEALTH SURVEY STAFF

SELECTED FINDINGS

oss of teeth occurs most often as the result of two f the most common diseases affecting the American eople—dental decay and periodontal disease. Dur- g his lifetime, nearly every person has one or both f these ailments, and when treatment is too long de- yed, tooth loss results. Accrued tooth loss in indi- iduals leads ultimately to edentulousness—total loss f permanent teeth—and the number and distribu- ion of edentulous persons provide an index to both he prevalence of dental disease and the extent of ental neglect in the U. S. population.

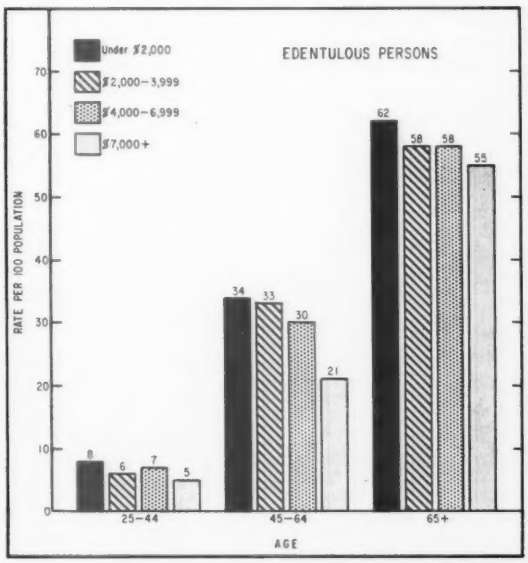
Based on health interviews conducted by the U.S. National Health Survey during July 1957-June 1958, there were approximately 22 million edentulous persons in the United States—13 percent of the population of the Nation. A person was classified as edentulous if he had lost all of his permanent teeth, regardless of whether or not he wore dentures.

Only 4 percent of persons 25-34 years of age were edentulous, but the percent was higher in each succeeding age group, reaching 67 percent for persons 75 years of age and over. In each of the age groups, the proportion edentulous was slightly higher for women than for men.



Source: U. S. National Health Survey

Figure 1. Rate of edentulous persons per 100 population by residence and age.



Source: U. S. National Health Survey

Figure 2. Rate of edentulous persons per 100 population by family income and age.

Rural areas had a somewhat higher percent of edentulous persons than did urban areas and the proportion edentulous was substantially higher in the white population than in the nonwhite population.

In general, the proportion edentulous was smaller among members of high income families than among members of low income families, and smaller for persons in families where the head of the family had at least one year of college than for persons in families where the family head had less education.

Edentulous Persons

Approximately 22 million persons, 13 percent of the population of the Nation, are edentulous.

This finding is based on responses to the question "Is there anyone in the family who has lost all of his teeth?" Persons who had lost all of their permanent teeth were classified as edentulous in the survey regardless of whether or not they wore dentures.

The proportion edentulous increased markedly with age, as would be expected. Virtually no one under 15 and only about 1 percent of those 15-24 years of age were edentulous. The proportion edentulous increased to 22 percent for those in the 45-54 year age group and increased to 67 percent for those 75 years of age and over.

The proportion edentulous was higher for women than for men in each of the separate age groups 25 years and above. For all ages combined, 14 percent of the female population and 12 percent of the male population were edentulous.

The proportion of persons who are edentulous was higher among rural than among urban resid as may be seen in figure 1. When the population w divided into more detailed residence groups, a cl relationship between the proportion of edentulo persons and degree of urbanization occurred amo women in each of the separate age groups. In ge eral, the proportion was lowest among women livi "Inside urbanized areas," and highest for rural-far women. The relationship for men was not as pr nounced.

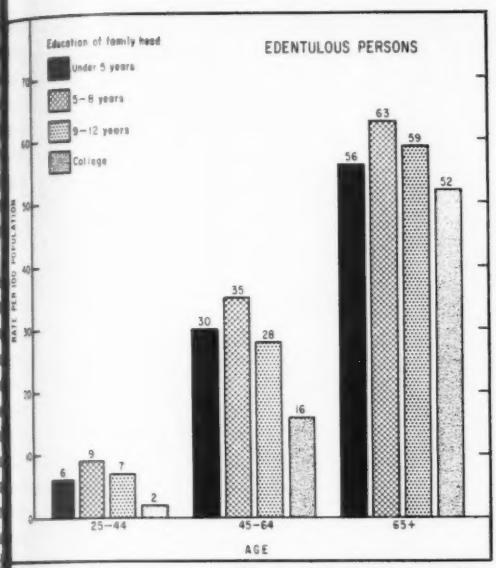
Data on total number and percent of edentulo persons are presented for the four separate ge graphic regions of the Nation. The percent edent lous varied somewhat among the four regio Within each of the separate age groups 25 years an over, residents of the Northeastern region had th lowest rate and those living in the North Centra region had the highest rate of edentulous perso

There were large differences between the two r cial groups with respect to rates of edentulous pe sons. The proportion of the white population th had lost all of their permanent teeth was muc higher than that for the nonwhite population. Abo 30 percent of white persons aged 45-64 were edent lous, as compared with only 17 percent of nonwhi persons. Corresponding figures for persons 65 yea of age and over were 61 percent edentulous for th white population and 43 percent for the nonwhi population.

When the population of the Nation was classifi according to family income, differences in the pr portion of persons who were edentulous occurre among the various income groups. The higher th

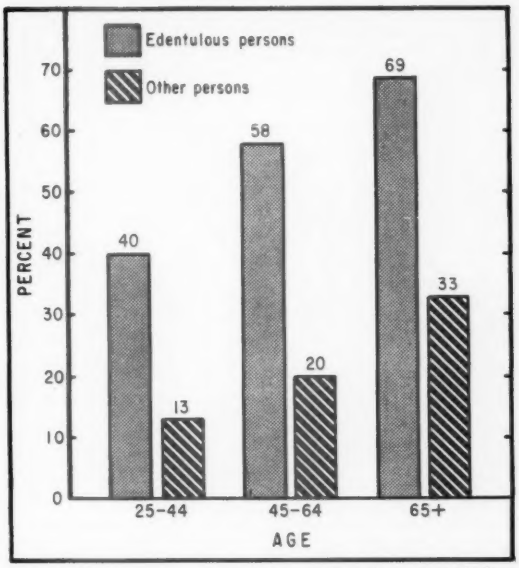
TABLE 1. NUMBER AND RATE PER 100 POPULATION OF EDENTULOUS PERSONS BY FAMILY INCOME, EDUCATION OF FAMILY HEAD, AND AG UNITED STATES, JULY 1957-JUNE 1958

Age	Total	Family income and education of family head				Income or education unknown
		Under $4,000		$4,000+		
		Under 9 years	9+ years	Under 9 years	9+ years	
	Number of edentulous persons in thousands					
All ages	21,881	7,638	2,978	3,855	5,136	2,274
0-24	220	46	(*)	46	77	(*)
25-44	3,008	494	381	589	1,341	202
45-64	10,037	3,048	1,148	2,279	2,511	1,052
65+	8,616	4,049	1,415	941	1,207	1,004
	Rate per 100 population					
All ages	13.0	21.9	12.0	15.6	7.2	17.4
0-24	0.3	0.3	(*)	0.5	0.2	(*)
25-44	6.6	7.8	5.9	9.6	5.6	7.4
45-64	29.1	35.3	29.3	33.0	22.0	29.3
65+	59.4	62.3	58.3	58.6	56.0	55.1



Source: U. S. National Health Survey

Figure 3. Rate of edentulous persons per 100 population by education of family head and age.



Source: U. S. National Health Survey

Figure 4. Percent of edentulous and other persons who had not visited a dentist within the past 5 years by age.

family income, the smaller the proportion of persons in that income group who had lost all of their permanent teeth. Among persons 65 years of age and over, for example, 62 percent of persons in families with incomes under $2,000 were edentulous as compared with 55 percent of persons in families with incomes $7,000 and over (fig. 2).

The percent edentulous was also computed for the different groups classified according to the educational attainment of the head of the family. As may be seen in figure 3, the percent edentulous first increased and then dropped as the educational level of the family head increased. When family income and education of family head were cross-classified, the "low education-low income" group had the highest proportion edentulous and the "high education-high income" group had the lowest. The two remaining groups occupied middle positions (table 1).

Time Interval Since Last Dental Visit and Rate of Dental Visits

Edentulous persons and persons who had some or all of their natural teeth were classified according to the time interval since their last dental visit (fig. 4). Any visit to a dentist for treatment or advice was considered to be a dental visit, regardless of whether the service was provided by a dentist himself or by a dental hygienist working under a dentist's supervision.

In each of the separate age groups, 25 years and over, the proportion of edentulous persons who had visited a dentist during the 1-year period prior to interview was substantially below that for the remainder of the population.

The proportion of edentulous persons visiting a dentist within the year decreased with age from 18 percent for persons 25-44 years of age to 7 percent for persons 65 years of age and over. The higher percent of persons with recent dental visits in the younger age groups is undoubtedly due to a comparatively larger proportion among the younger edentulous persons who only recently lost all of their teeth.

For both edentulous persons and persons who had their natural teeth, the percent who had not visited a dentist for 5 years or more increased with age. For edentulous persons the figures varied from 40 percent for persons 25-44 years of age to 69 percent for those 65 years of age and over. Corresponding figures for other persons were 13 percent and 33 percent (fig. 4).

The rates of dental visits for edentulous persons also fell considerably below those for persons with natural teeth. While there was little difference in the rates for persons 25-44 years of age, the differences were considerably larger in the older age groups. The decrease in rate of dental visits from 1.5 visits per person per year for those 25-44 years of age to 0.5 visits for those 65 years of age and over,

is again probably related to the decrease in the proportion of persons who recently became edentulous. While dental visits for edentulous persons included such services as checkup, denture repair, gum treatment, and fittings for new dentures, they also included visits for tooth extraction and fitting of the initial set of full dentures for persons who recently lost all of their teeth. These latter services generall involve a number of dental visits. Consequently, those ages where the proportion of persons who re cently became edentulous is large, their dental visi rate would be expected to be relatively higher tha in groups where persons had been edentulous fo some time.

TABLE 2. NUMBER AND RATE PER 100 POPULATION OF EDENTULOUS PERSONS BY REGION, SEX, AND AGE: UNITED STATES, JULY 1957-JUNE 1958

[Data are based on household interviews during July 1957-June 1958. Data refer to the civilian noninstitutional population of th United States. Detailed figures may not add to totals due to rounding.]

Sex and age	Region				
	All regions	Northeast	North Central	South	West
	Number of edentulous persons in thousands				
Both sexes					
All ages	21,881	5,256	7,248	6,366	3,011
0-24	220	51	68	76	(*)
25-44	3,008	682	1,048	814	464
45-64	10,037	2,498	3,240	2,983	1,316
65+	8,616	2,024	2,892	2,492	1,208
Male					
All ages	9,730	2,236	3,275	2,833	1,387
0-24	105	(*)	41	(*)	(*)
25-44	1,245	299	442	328	175
45-64	4,668	1,116	1,510	1,406	636
65+	3,713	793	1,282	1,072	566
Female					
All ages	12,151	3,020	3,973	3,533	1,624
0-24	115	(*)	(*)	50	(*)
25-44	1,763	383	605	487	289
45-64	5,370	1,383	1,730	1,577	680
65+	4,903	1,231	1,610	1,420	642
	Rate per 100 population				
Both sexes					
All ages	13.0	12.5	14.4	12.3	12.5
0-24	0.3	0.3	0.3	0.3	(*)
25-44	6.6	5.7	7.7	6.1	6.8
45-64	29.1	25.0	32.0	30.3	29.2
65+	59.4	53.5	62.1	61.1	60.5
Male					
All ages	11.9	10.9	13.2	11.3	12.0
0-24	0.3	(*)	0.4	(*)	(*)
25-44	5.7	5.3	6.7	5.2	5.4
45-64	27.9	23.1	30.2	29.8	28.8
65+	55.9	48.9	58.7	57.1	59.3
Female					
All ages	14.1	14.0	15.5	13.2	13.1
0-24	0.3	(*)	(*)	0.4	(*)
25-44	7.4	6.2	8.6	6.9	8.1
45-64	30.3	26.8	33.7	30.7	29.5
65+	62.3	57.1	65.1	64.6	61.6

HOW TO FIGHT AN ECONOMIC PINCH

By CHARLES FITZ-PATRICK

This tested advice is offered to help you keep your practice financially sound, regardless of economic developments.

There are men and women among your patients who think first of the dentist when they have a real or imagined need for tightening their budgets. Their actions may be prompted by an actual falling off of income or simply by the influence of unfavorable financial news. Instead of calling at their usual times for appointments, they may be tempted to "wait until next month" or suggest to you that only their most urgent dental problems be given attention.

All this can result in a now-and-then blank period in your appointment book, a lowering of your work volume, a slow-down in fee payments, and a feeling of frustration on your part. You may not be in a position to eliminate such conditions completely, but their consequences may be minimized through prompt and aggressive action. For instance, the suggestions offered below are applicable to the so-called average practice and may be put to work easily and inexpensively with surprisingly beneficial results.

Dollar Competition

Most of your patients have a limited number of dollars to spend, but the problem they face regularly is not the percentage of this money that will be devoted to your services as opposed to that of another practitioner. It is more serious than that. These folks may weigh the desirability of dental corrections against a new TV set, some room decorations, a more lengthy vacation, or tires for their car.

Thus your office is actually in competition with the appliance retailer, the resort motel, the clothing manufacturer. During a period of tight money, a patient's decision to telephone you may be the result of early education in oral health. It could be the result of the minute or two you devoted earlier to explaining the economy of regular appointments, the advisability of having preschool children included in the family's office visits, or your explanation of the social and business benefits of good dental appearance.

Since adult dental education is limited chiefly to instructions from dental practitioners, your chairside efforts in this direction today can influence the number of calls you receive next month and next year.

Aggressive Collection Efforts

The professional man's bill frequently finds its way to the bottom of the pack simply because the patient feels he will not be pressed to pay the fee promptly.

This belief is due in part to the former delay of some dentists in submitting charges for their services. Today the sound practice is to bill within 24 to 48 hours because this indicates your interest in receiving the amount due you. From the patient's standpoint, he is likely to hesitate less about making prompt payment because he is still conscious of the benefits enjoyed from your services.

A mail follow-up within three weeks is also in order if a patient has not met his financial obligation by then. (In some non-professional circles there are organizations that attach an interest charge to bills not paid within set due dates, say 10 days, three weeks or a month. This is being done to compensate for the loss of the use of the money to discount bills and to balance the purchasing power drop caused by inflation.) A telephone call to a patient

by your office assistant is in order when the delinquency passes the 30-day mark.

Your Buying

The commercial you hear that suggests the purchase of the "giant economy size" may have its counterpart in some of your own buying. Those materials and supplies you use regularly, but now order hand-to-mouth, possibly could be had for less. You might review your orders, purchase records, and other pertinent data in this connection.

Economists who have carefully reviewed such matters insist that some kinds of buying can be as important as selling when building profits.

Ask Your Banker

If you have not yet established an outside financing arrangement for patients requiring extensive operations, it may be worth-while to talk over such a plan with an official of a neighboring lending institution. This will relieve you of the risk of financing patients' work, the problem of credit investigation, as well as troublesome collection and bookkeeping details. Also, a plan of this sort will permit you to concentrate on your professional dental tasks, while financial experts look after the dollar considerations.

In your selection of a financial house decide on only the very best. Inquire about its public relations and its collection methods. Learn all you can, so as to determine if the organization's technics will reflect favorably on you as a professional man.

Recall Notices

There is no longer any doubt that notifying a patient that six or eight months have passed since his last appointment does speed up the early return of the patient. But it is also true that today the pressure on most men and women may cause them to fail to act immediately and then forget their intention to telephone you. For this reason it is desirable for you and for your patient that a second and possibly a third reminder be mailed. The second should be sent one month after the initial recall notice. The third one or two months after the second reminder.

In some offices it has been found helpful to set up a definite day and hour for the next appointment—even if six or eight months later. This information is then included on the recall card together with the request that the patient telephone to confirm the arrangement—and the fact that he intends keeping it—two days before the actual date. When not confirmed, the dentist is then free to give the time to someone else. However, a profitable percentage of those reminded under this system do keep the appointment.

Freshening Up the Office

Several times a year arrange to have the furniture in your reception room shifted about after the area has been given one of its regular housecleanings. This is desirable for two important reasons. First of all, it tends to give the room a different appearance and offers you an opportunity to clear out those things that have outlived their usefulness—the end-table with the wobbly legs, the plant that has grown limp, the discolored lampshade, and magazines now outdated. Secondly, the redistribution of the furniture helps distribute wear of the upholstery, rugs, lamps, and tables.

Conclusions

Your application of these suggestions will step up the conduct of your practice and, in doing so, will make you less vulnerable in the event of an economic pinch. The reason is quite simple. Several of these tips are intended to aid in getting the money due you and to make it possible for you to make more and better use of these funds. The other recommendations are pointed toward pleasing the patient. These are vital because the patient likes to be made to feel wanted. An interesting survey has revealed that men and women exchange their dollars more willingly in those places where they are made to feel wanted and important.

One need not turn to Freud for an explanation of this. After all, don't you like to deal with one professional supplier more than another? And when you make a referral to a specialist, aren't you influenced by that specialist's interest in, and courtesy to, you and your patient?

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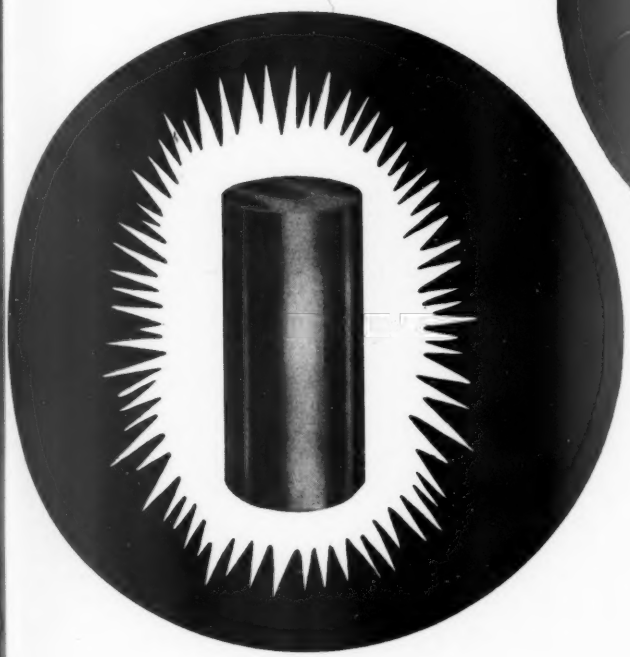

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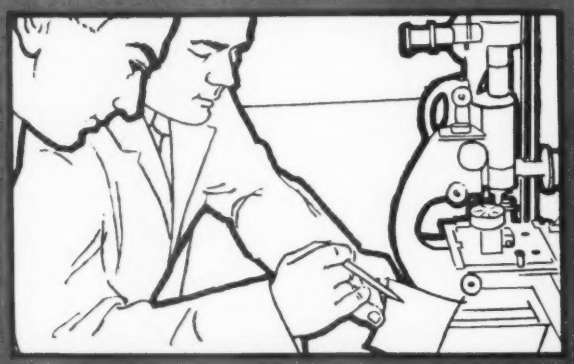

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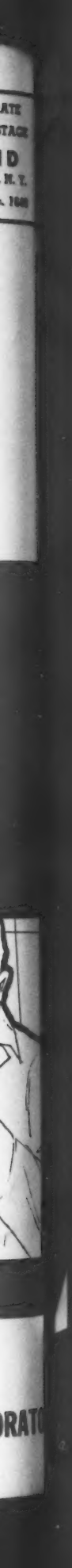
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